MDR Tracking Number: M5-05-0266-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 9-17-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The office visits, modalities, therapeutic procedures and muscle testing from 12-3-03 through 3-29-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-18-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 97124 for date of service 3-19-04 was denied with an "F" – MAR reduction. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale

for not doing so. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge). **Reimbursement is recommended in the amount of $37.33.**

CPT code 97140 for date of service 3-19-04 was denied with an "F" – MAR reduction. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of $32.90.**

CPT code 97750-FC for date of service 3-29-04 was denied with an "F" – MAR reduction. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Reimbursement is recommended in the amount of $249.62.**

This Finding and Decision is hereby issued this 3rd day of January 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);
plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 12-3-03 through 3-29-04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 3rd day of January 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

RL:da

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-0266-01
Name of Patient:	
Name of URA/Payer:	Alta Healthcare Clinic
Name of Provider: (ER, Hospital, or Other Facility)	Alta Healthcare Clinic
Name of Physician: (Treating or Requesting)	Luz Gonzalez, DC

November 15, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Available information suggests that this patient reports a work related injury to her neck and right shoulder on ___. She appears to have presented initially to Concentra but no documentation of this is provided for review. She also appears to have had several months of unsuccessful chiropractic care, but no specific documentation of this is provided for review. She appears to have undergone cortisone injections to the right shoulder with some success. Cervical MRI is obtained indicating a disc bulge at C5/6 segments and MRI of the right shoulder suggesting a SLAP lesion to the superior labrum. The patient has surgical repair of the right shoulder on 12/08/03 by orthopedist, Dr. James Key. A post surgical physical therapy order is made by Dr. Key on 01/19/04 suggesting light ROM and modalities daily for 2 weeks then 3x per week for 4 weeks. The patient begins post surgical therapy with a chiropractor, Dr. Luz Gonzalez with multiple modalities an active therapeutic exercise from 01/20/04 to 03/29/04.

REQUESTED SERVICE(S)
Determine medical necessity for office visits, reports, modalities, therapeutic procedures and muscle testing for period in dispute 12/03/03 through 03/29/004.

DECISION
Approved.

RATIONALE/BASIS FOR DECISION
Medical necessity for these ongoing treatments and services (12/03/03 through 03/29/04) **are generally supported** by available documentation.

1. Nicholson, G.G. "Rehabilitation of Common Shoulder Injuries." Clin in Sports Med. 1989 8:(4) pg. 633-655.

2. Hurwitz EL, et al. The effectiveness of physical modalities with randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. J Manipulative Physiol Ther 2002; 25(1):10-20.

3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.

4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec, 2002.

5. Brotzman B, Wilk K, "Clinical Orthopedic Rehabilitation," 2nd Ed., ISBN 0-323-01186-1, Mosby Press, 2003, pp. 236-238.

6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

7. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided.

It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.